LIBRARY

A Case of Oligo Hydramnios with partial amputation of a foot occuring in a Uterus Unicornis.

Leonard C. Blackstone Lancet. Vol I. 1909 p. 761

The patient a woman aged 30 gave birth to a premature female child (16 inches long), in October 1908. Labour was complete in 2½ hours. The patient states that she lost no "waters" either before or with the birth of the child. The midwife who arrived a few minutes after the child was born found the bed dry.

The child's left foot was swollen and oedematous and a tough fibrous band was found twisted twice round the leg ¾" above the ankle. On the removal of the constricting band the skin was found to be divided round the whole circumference of the leg. The child was able to flex and extend the foot and toes, proving the tendons, etc. undivided. There were no congenital deformities; the skin was normal and no renal or cardiac affections could be detected. The oedema of the foot had completely disappeared ten days after birth, and the skin lesion healed. The child died three weeks after birth from marasmus.

The third stage of labour lasted half an hour. The maternal surface of the placenta was ragged and torn; the whole of the chorion and the greater part of the amnion were retained. A tough amniotic adhesion stretched from a point on the funis 2" from

the placental end to be attached to the foetal surface of the placenta 3" from the insertion of the cord. This band was 4½" long and varied in breadth from 1" at the funic attachment to ½" at the placental attachment. From the same position on the cord another band ran to join the amnion close to its junction with the placenta. This was 9" in length and 4" broad at its outer attachment. The tough cord-like adhesion removed from the child's leg was 6" long and one-sixth of an inch in diameter.

Ergot was prescribed, and the retained membranes were expelled with the lochia on the third day, and were unfortunately destroyed without examination.

The lying-in period was normal.

The previous obstetrical history of the patient is interesting.

Her first child, now five years old, presented by the face but was born without any operative interference. Seven months later the patient was operated on by Mr. Alban Doran at the Samaritan Hospital for a ruptured Cornual Gestation - the right cornu and appendages were removed. This case was published in the Journal of Obstetrics & Gynaecology in June 1906 by Mr. Doran.

One year later the woman gave birth to another child, presented by vertex. In this confinement there was some delay in third stage.

After a further eighteen months, the patient had another

child, this presented by the breech. In this case the third stage lasted over two hours, and part of the membranes was retained.

The patient has developed a ventral hernia in the upper part of the abdominal scar; the hernial aperture after her last confinement easily admitted the hand and made palpation of the uterus extremely easy.

The asymetry of the uterus and the absence of broad ligament on the right side was very noticeable.

Doran

[Reprinted from the "Journal of Obstetrics and Gynæcology of the British Empire," June, 1906.]

Vol 9. p 440 17

Cornual Gestation : Rupture : Pregnancy in Opposite Cornu after Operation.

See also "Two Cases of Interstitial Septic Gestation both associated with Fibromyoma" & "The Method of Cornual Excision" Lancet Vol I p 503

BY

ALBAN DORAN, F.R.C.S.

SHERRATT & HUGHES
60 Chandos Street London W.C.
27 St. Ann Street Manchester

V.

Cornual Gestation: Rupture: Pregnancy in Opposite Cornu after Operation.

By Alban Doran, F.R.C.S.,
Surgeon Samaritan Free Hospital.

Early in the autumn of 1904 the following case occurred in my operative practice. I removed a cornual sac for acute hæmorrhage due to its rupture, and was able to save the opposite cornu. That cornu, which had already been the seat of two normal pregnancies before the operation, has once more carried a child safely to term since I amputated the cornual sac. I will now relate the case, dwelling afterwards on questions of interest in relation to it, such as the simulation of Hegar's sign, the absence of vaginal "show," and the high importance of after-histories in cases of this kind:—

D.P., aged 27, applied for relief at the out-patient department of the Samaritan Free Hospital on September 7th, 1904, at 1-30 p.m., suffering from acute abdominal pain with marked anæmia. She was very ill-nourished, being the wife of a day-labourer, residing in the poorest quarter of the Latimer Road district. She had been married for over two years, and borne two children; the youngest, seven months' old, had been weaned three weeks before the patient was brought to the hospital. No show had been seen since the second labour, except on one occasion, when the child was four months old, and the patient believed that she was once more pregnant.

On the evening of September 5th an acute attack of hypogastric pain occurred, and lasted all night. Next morning, when the patient rose, she felt pains distinctly crampy in character, and became faint. The symptoms subsided towards the evening, and on the morning of September 7th she felt better still, but considered that it was prudent to state her case at a hospital. Mr. A. Lionel Smith noted: "In the middle line of the abdomen is a mass of about the size of a uterus in the fourth month. On vaginal examination the mass in the abdomen is felt to be continuous with the cervix, but the thinning of the supra-vaginal portion of the cervix is much more marked than usual." There had been no "show" of blood during or before the three days' attack of pain. Mr. Lionel Smith induced the patient to rest in the waiting-room for a while. At 5-30 p.m. she felt very faint. At 8-30 p.m. Dr. Cuthbert Lockyer saw her. A severe attack of syncope

had occurred, and the patient was admitted. At 9 p.m. I was sent for, as she had fainted once more. The mass in the middle line could no longer be defined, and there was dulness over the right side of the abdomen as well as over the hypogastrium. For the first time, a little vaginal "show" was detected. The pulse was 120, small and thready.

I operated at 9-30 p.m., assisted by Dr. Lockyer, Mr. Lionel Smith administering chloroform. On opening the peritoneal cavity, much fluid blood escaped, with masses of recent clot. I at once seized and clamped a body which looked like the uterus and showed a ragged laceration, about four inches long, on its upper surface towards the left. Placenta and membrane protruded from this laceration, and were traced upwards under the omentum to a fœtus three inches long, lying intact in its amnion. The inner side of the lacerated sac was connected with what I found to be an empty left uterine cornu by a band, free above and continuous with the cervix and pelvic structures inferiorly. The right ovarian vessels were ligatured in the infundibulo-pelvic ligament, and then the band was secured. As all hæmorrhage now ceased, I was enabled to examine the relations of the sac, and found that the right tube ran entire from its outer border to which the ovary was also attached. The sac, shaped somewhat like a paper fruit-bag over four inches square, was internal to the right round ligament which ran from its outer border. The band was transfixed and ligatured with No. 4 China-twist silk and then divided; it became very narrow when the ligature was drawn tight. Thus the ruptured sac came away with the right appendages, whilst the left cornu was saved. I noted that the left tube and ovary were normal. The peritoneal cavity was freely washed out with saline solution, several pints of which were closed up in that cavity when the abdominal wound was sutured.

There was but little rise of temperature after the operation, and the maximum, 100·3°, on the evening of the third day, was apparently due to irritation caused by the presence of scybala in the lower bowel, a common complication after emergency operations. Under the influence of strychnine the pulse rapidly improved. On the second day a discharge of blood from the vagina was noted. It was never free, but became fœtid and mixed with mucus on the fifth day, without rise of temperature, and disappeared a day or two later. Nothing resembling a decidua was detected in the discharge.

After History. When the patient left the Samaritan Hospital, the period reappeared while she was at a convalescent establishment, and was seen twice again, at regular intervals. Then she became

a third child was born on October 21. 1908 Haemorrhage for six weeks before delivery. Amniotic bands present; partial amputation of right foot She had recently attended Dr Maxwell in O. P. Dept of S F H. Dr Henderson of Queen Charlotte's Hospital called & asked Dr & Clifford White about her & I sent him a reprint of Starr Jackson. Dr Reilly of St. H. sent me the enclosed letter with a report of the Cardiff Labours Published by Dr Leonard Blackstone Lancet "A Case of Chloroform Pneumonia (sic) with partial decapitation of a foot occurring in a Utterus Unicornis" Lancet Vol I. 1909 p. 761 (Enclosed (3)

pregnant. Labour occurred at term on September 13th, 1905. There was difficulty in micturition during the last three months, and labour was, it appears, impeded by great distension of the bladder. When the catheter was used the labour terminated spontaneously without further trouble. There was no post partum hæmorrhage. The patient has seen no "show" since her last confinement, but she is still suckling her child. Ever since the operation she has been subject to attacks of vertigo, without ever fainting. For this important after-history I was obliged to seek the patient herself, as she had changed her address, but after numerous enquiries in the neighbourhood, I found her (May 3rd, 1906) in a back street in Notting Dale, and for the first time learnt that pregnancy had occurred in the cornu which I was able to save. Her health is fairly good considering her circumstances.[x]

The parts removed will be minutely described by my friend and colleague Dr. Cuthbert Lockyer, who, I understand, is preparing a monograph on cornual pregnancy, which will be in some respects a continuation of our joint paper on "Two Cases of Uterus Septus Unicollis, both associated with Fibro-myoma, and one also with Hæmatosalpinx," which appeared in this JOURNAL, in March, 1905. At present I need dwell on little more than purely clinical and surgical questions, especially as there can be no doubt that the fœtal sac was the right cornu of the uterus.

These clinical and surgical questions will now be discussed in detail:—

1. Intra-peritoneal hæmorrhage was evident, and ectopic gestation was diagnosed. We had little doubt that rupture of the sac had occurred, but the patient's condition was so grave that I made all haste to open the abdomen and stop the hæmorrhage without attempting to define the precise nature of the abnormal pregnancy.

2. In this instance of cornual pregnancy no "show" of blood was observed from the beginning of gestation until about half an hour before operation. During the acute symptoms in the course of the last three days before the sac was removed not a trace of blood escaped from the genital canal. After the operation there was a distinct discharge of blood which became fœtid. Hæmorrhages from the normal cornu are the rule in cases of pregnancy in a closed cornu. Clinical evidence has shown that the discharge of the decidua from the normal cornu bears little, if any, relation to the progress or arrest of the pregnancy. In tubal gestation discharge of decidua from the uterus is very often associated with arrest of the abnormal pregnancy, and is therefore a valuable monitor to the surgeon. The bloody

[x] a second child born alive Oct. 12, 1907. Breech labour, midwife Miss Rees Charlotte Street, alive & well. Ex. Nov. 29, 1907. Big in cornual region. Uterus normal. Left ovary & tube in front of body of uterus which was drawn. Pt. [illegible] D. finished. See special note Book

discharge after the operation in this case possibly represented the expulsion of the remains of a decidua long broken down. If so, however, it is strange that a show of blood had not occurred much earlier before operation.

3. As is the rule in cornual and the exception in tubal pregnancy, the patient did not suffer from pain until the rupture took place. The escape of blood into the cavity of a healthy peritoneum causes distinct pain, and therefore explains the earlier acute symptoms in this case. A few hours later the pains became cramp-like, that is to say, the cornu contracted occasionally, expelling its contents. It did not succeed in emptying its cavity of the entire placenta. As its walls were fairly thick, and made up of uterine muscular tissue, it is easy to understand why these crampy pains set in, and were clearly distinguished and described by the patient.

4. The gravid cornu had risen entirely above the pelvic brim, and thus was exposed to damage. Rupture is rare during the first three months of cornual pregnancy, but more frequent later when the cornu is no longer a little sac lying well protected down in the pelvic cavity.

5. The source of the intra-peritoneal hæmorrhage was manifest. Rupture of the sac is the most frequent cause of interruption of a cornual pregnancy; in tubal pregnancy it is now known to be otherwise. Death of the fœtus and its retention in the cornu for an indefinite period has been frequently recorded.

6. One of the most instructive features in this case was the apparent thinning of the supra-vaginal portion of the cervix, which Mr. Lionel Smith carefully noted as being much more marked than in a normal pregnancy. The thin portion was no doubt the band connecting the gravid cornu with its fellow and with the cervix; morphologically the lower part of the band was really cervix. As the gravid cornu had come to lie almost vertically in the middle line, its longitudinal axis was practically continuous with that of the vaginal portion of the cervix. Thus we see how early normal pregnancy may be simulated by cornual gestation, the band giving a false impression of "Hegar's sign" when the cervix is examined by the bimanual method.

7. The fœtus measured a little over three inches in length. Making allowance for relative ill-development, the pregnancy might have reached the middle of the third month. Conception during lactation, however, made such calculations very uncertain in this case. The fœtus was quite fresh, and must have been alive when the acute symptoms began. Death of the fœtus in a cornual sac

QUEEN CHARLOTTE'S HOSPITAL,

MARYLEBONE ROAD, N.W.

TEL. 1791 PAD.

26, UPPER WIMPOLE STREET,

W.

July 6. 09.

Dear Mr Doran

My specimen is

a "bottled" one

a primigravida

The patient was five

months pregnant & died

15 min: after admission

from internal haemorrhage

so that the question of operation

discharge after the operation in this case possibly represented the expulsion of the remains of a decidua long broken down. If so, however, it is strange that a show of blood had not occurred much earlier before operation.

3. As is the rule in cornual and the exception in tubal pregnancy, the patient did not suffer from pain until the rupture took place. The escape of blood into the cavity of the abdomen
distinct p
this case.
say, the c
not succe
walls wer
is easy to
distinguis

4. The
thus was
months of
is no long

5. The
Rupture o
cornual p
otherwise.
indefinite

6. One
apparent t
Mr. Lione
in a norm
connecting
morpholog
the gravid
its longitu
vaginal p
pregnancy
a false im
by the bin

7. The
Making al
have reac

lactation, however, made such calculations very uncertain in this case. The fœtus was quite fresh, and must have been alive when the acute symptoms began. Death of the fœtus in a cornual sac

ould not omit

as the specimen is a

. m. one it shows the relation

the various structures

onically. I think it is

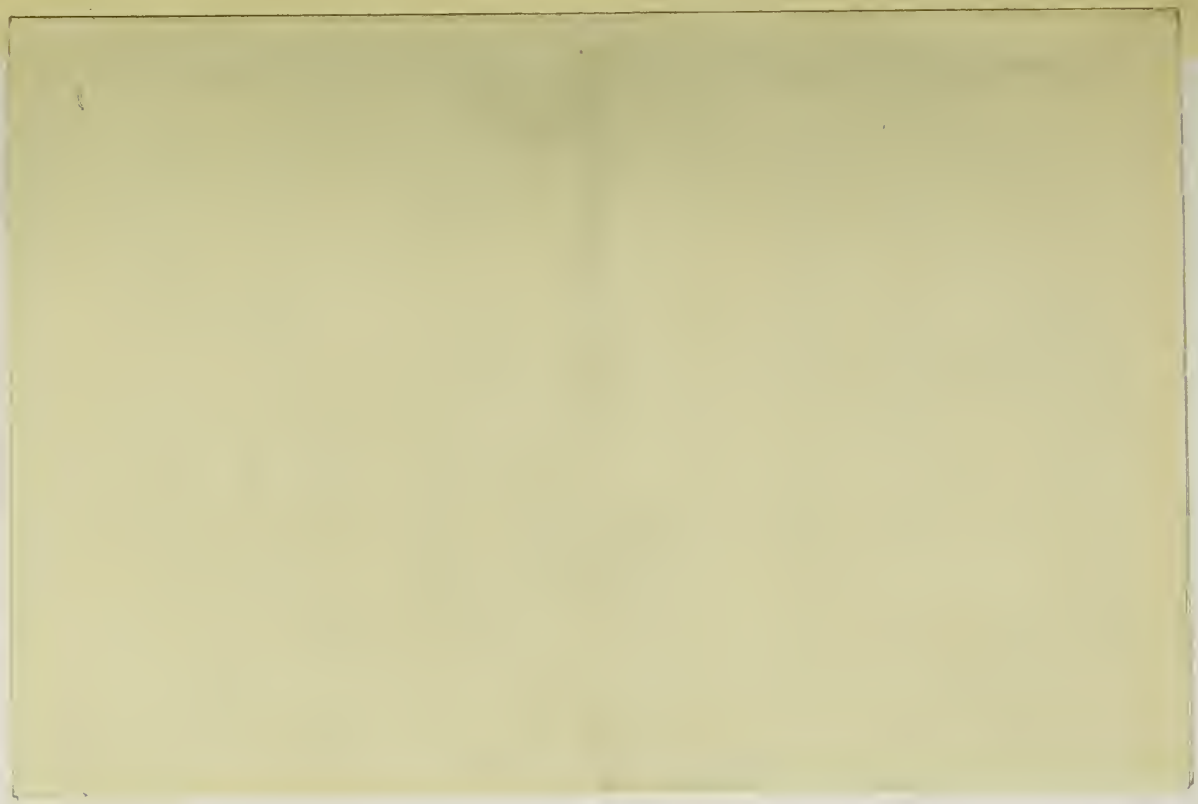
ne of the best of the kind

I have ever seen exhibited

With kind regards

Yrs very truly

Abernethy Willett



QUEEN CHARLOTTE'S HOSPITAL,

MARYLEBONE ROAD, N.W.

Mrs Louisa Lawrence
Petersham
in July
1909

25. 10. 05.

Dear Sir

Thank you very much for your letter & interesting paper re Mrs Peach. The last confinement was a case of Chgo hydramnios with attempt at amputation of the childs left leg. Her first confinement was a face presentation: due I presume to the asymetry of the uterus. This was followed by the normal gestation & operation. Her next confinement was

(3)

her confinement was at times severe
She did not send for our midwife
nor was she seen by any doctor.
Her last confinement was very easy
the child being premature 32-36 weeks
& the afterbirth came away quickly.
There was very little liquor. The after-
birth ~~was~~ is very rough, & fibrotic, incomplete
the greater part of both chorion & amnion
being left behind. There is a strong
band of adhesion extending from
the cord to the ~~foetal~~ surface of the placenta

(5

a tough adhesion was wound twice
round the child's left leg. The nurse
had some difficulty in undoing the later
which had cut through the skin all
round the leg. She developed a
small ventral hernia in the upper
half of the scar after her second
confinement & this has enlarged
each subsequent pregnancy &
now admits the half hand & the
asymetry of the uterus is very easily
palpable through it & most marked.
She still has some tenderness in the
~~iliac~~ region
~~scar~~ just to the left of the lower
half of the uterus but I could.

in this
ta & the
te leg in
care
should
them
the case
hild's leg.

(2)

normal except for some slight difficulty in the separation of the placenta. Her third child presented by the breech & here there was again delay in the separation of the afterbirth it being about one hour before it could be expressed. Nine weeks ago she had severe pain in the left side & was seen in the Out-patient department of the Samaritan by Dr Maxwell but no cause for the pain was found. Six weeks before her confinment she started to loose blood & this loss was continuous until the time of

QUEEN CHARLOTTE'S HOSPITAL,
MARYLEBONE ROAD, N.W.

(5

detect nothing abnormal in this region. I have the placenta & the adhesion removed from the leg in the hospital & if you would care to see them at any time I should be very pleased to show them to you. I hope to publish the case with illustrations of the child's leg.

(2)

norma

difficul

placenta.

the brea

delay in

it being

could h

she has

& was

of the

but no

found.

she star

was con

(6)

& the afterbirth & should like to refer to her previous history & to mention your paper as reference if you will permit me to do so.

Yours sincerely

Leonard. C. Blackstone

HOSPITAL FOR WOMEN & CHILDREN
LEEDS

7. 7. 09.

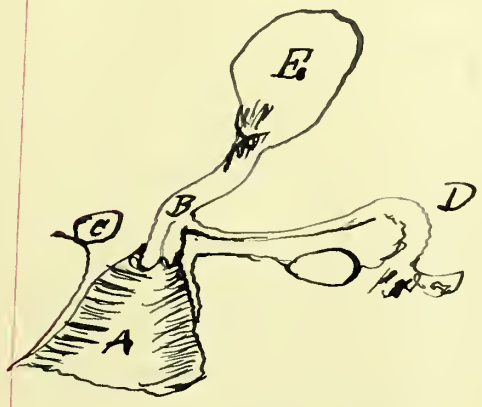
Dear Sir

I have only just received your letter. I am sending you the case as I published it. It was in the Lancet in March I believe in or about the 13th. The cornual gestation was her second pregnancy.

Yours faithfully

Leonard. C. Blackstone.

Absence of body of uterus & right appendages;
presence of myoma & calcified dermoid
("Further Observations of Density
of the Female Generative Organs, and
causes of Symptoms simulating Incipient
Pregnancy". John M. L. Macewen
M.B. &c Senior Assistant to the Regius Prof. Surgery,
Glasgow. "Lancet I. 1911 p. 790 (March 25).



A. Vagina laid open
B. Rudimentary uterus
connected by pedicle to
myoma (E). C. Stump of
replacing right appendages
D. Left appendages. E. Myoma
replacing fundus uteri

as a rule means its indefinite retention. The familiar results of tubal mole and tubal abortion are not seen in cornual pregnancy.

8. The fact that there was a distinct band between the gravid cornu and the remainder of the uterus is of great interest for surgical reasons. Dr. Lockyer found that the band did not include a canal communicating with the cervix or with the cavity of the normal cornu. As this report is mainly clinical, I need not discuss the question of transmigration of the ovum. I must dwell on the fact that the presence of a well-defined band allows of an essentially conservative operation, the healthy cornu being saved, so that it may become the seat of a normal pregnancy. This happens to be the second case in which I have removed an abnormal cornu from a woman who had borne children in the opposite cornu, and in both instances the normal cornu became the seat of pregnancy after the operation.

The first patient underwent operation when 38 years of age on January 3rd, 1899.* I removed an undeveloped right cornu which had become the seat of a myoma. The patient had borne a live child and had also aborted once before the operation. As in the case of cornual pregnancy, I lost sight of the patient and had great difficulty in tracing her, until March, 1902, when she wrote to me, saying: "I had another child in 1901, and a fine big boy he is, now one year and a half old. I had a good quick time; he was born ten minutes before the doctor arrived."

We must bear in mind how very well the normal cornu in a double or one-horned uterus may carry on its functions. "As a rule, the course of pregnancy is not disturbed, and labour is easy and natural," says Professor Stephenson.† So it was in my two cases where the imperfect cornu had been amputated. On that account I consider that the operator is fortunate when he is able to save the unaffected cornu. In subjects where the bifurcation is not complete this conservative procedure may be impossible.

* "The Removal of a Fibroid from a Uterus Unicornis in a Parous Subject." *Brit. Med. Journ.*, Vol. I., 1899, p. 1389. This paper appeared before the patient became pregnant again.

† Art.: "Pregnancy," *Encyclopædia Medica.*

Bifid uterus: also its association with hermaphroditism

Addenda

See also notes appended to "Two cases of [illegible] Septa Longitudinalis Uteri" by Watkins. Reference of Gravid Bicornate Uterus Amer. Journ. Obstet. July 1906

Freund. Ueber atretischen Uterus bicornis. Zentralbl. f. Gyn. No 33 (p 934) 1906.

Kirchgässer Rupture of a gravid bicornate uterus associated w. atresia of rudimentary cornu. 2 pregnancies previously in each cornua. The abscinded cornua on the affected side were removed (Inaug. Dissert. Breslau) 1905. p 72 4. Monatsschrift f. Geb. u. Gyn. Sept 1906. p 364.)

West "Rupture of gravid rudimentary Bicornate Uterus" (Amer. Journ. Obstet. Sept. 1906. p. 403) No note as to whether the uterus was closed, & communicating with the vagina. Death.

" "Anatomische Befunde in einem Falle von Scheidenatresie" Archiv f. Gyn. Vol 81. Ht 2. p 369 (1907)

Van der Linden Case of pregnancy in left horn of a uterus bicornis; foetus retained 6½ m. Zentralbl. f. Gyn. No 26, 1908. p 93. & Journ. of Obst. & Gyn. Oct. 1908 (Vol XIV) p. 931.

Addison Rupture of a Bicornate Gestation Sac 4 hrs after Rel. Trans. B.M.J. Vol I 1906. p. 1235

Arnold's Pseudohermaphroditismus masculinus externus. Monatsschr. f. Geb. u. Gyn. Oct. 1908 (Vol 28) p 463 & Journal de Méd. de Paris 28 Juin & Revue mens. Bicornate Uterus w. tubes & ~~tubes~~ ovaries a mass taken for ovarian dis. & subsequently left tubes

Cornil & Bassoul Rev. de Gyn. et de Chir. Abd. "Un cas de co-existence dans la même espèce de 2 [illegible] uteri, des deux vagins et de deux hymens." (1908. p. 195. Mens-Gin

Babonix "Kyste de pedicule" dans la corne rudimentaire d'un utérus unicorne" (Comptes Rendus de la Soc. d'Obst. de Gyn. & de Paris. Feb-Mar 1909) & Annales de Gyn 1909) Rud. cornu was excised & ovary into vagina. Left alone. Menses after 2 mos of pregnancy

Cohen La Grossesse dans la corne accessoire ou atrésique d'utérus quasi cloisonné pl. Rev. de Gyn. et de Chir. abdom Vol XIII (1909) p. 2. (a very good summary)

Hoyle. Pseudohermaphroditismus masculinus completus. Zentralbl. f. Gynäk. 1909. p. 1266 (Society report) 46, 19 yrs m.º as ♀ 6 yrs a widow. Double inguinal hernia, left o/s no uterus but a testis, epididymis & ductus in ea. ch sac. Outer part normal, no bursa spadias of clitoris, vagina a blind sac. aspect, Hirsuties, Thyroid enlarged, voice feminine. Resp. abdom. in type. Testes with testicular tissue altered by degenerative & inflammatory changes, no spermatogenesis. Discussion; general impression was that the inguinal sac was artificial: due to attempts at pulling

Couvelaire et Guillaume. "Observation d'une femme ayant eu successivement: une grossesse dans une demi-utérus, une grossesse dans une corne rudimentaire et présentant une grossesse dans une trompe." Comptes rendus de la S.c d'Obstét. de Gynéc. et de Pédiatrie de Paris Vol 13. 1911. p. 59. & Annales de Gynéc. et d'Obstét. March 1911 (Vol 2nd series) p. 165

Beckmann. Weiteres Beitrag zur Gravidität im Rudimentärhorn uterus unicornis. Zeitschr. f. Geb. u. Gyn. Vol 68. p. 1. Tabulates 50 cases including 18-22, Hicks, Hollier.

Hicks & Hosker "Pregnancy in a Bicornate Uterus" Amer. Journ. Obst. Dec. 1912 (Vol 66) p. 253. & 42. yr.º 3 ch, 20, 17, 15 yrs no abort. Reduein Ovaria & corpus cavernosa (Gk) appendages removed abroad 2nd m.º Removal of L. membrane parasol 14 days. Recovery (in complete report).

Gross et Frankenholz Un cas de grossesse normale après hémi-hystérectomie. Annales de Gynéc et d'Obstét Déc. 1913 (2e. série tome X) p. 507.

Beside Uterus: also its association with hermaphroditism

... 00 C.

Hicks. H. D. "A Case of Ruptured Ectopic Gestation occurring in a Rudimentary Horn of a Uterus Bicornis Unicollis" Brit. Med. Journ. Vol I. 1900, p. 303

19

20

Pl. uterus gemellaris gravidus. Rev. de Gyn. et de Chir. abdom. Vol XIII (1909) p. 2.
(a very good summary)